

Evaluating Treatment Outcome

John Briere

Introduction

Once treatment has been initiated with a child victim, the periodic assessment of the client's psychological and social functioning — including a final assessment at the end of treatment — becomes an important aspect of ongoing clinical care. Whenever possible, such an assessment process should be formal (that is, psychometric) in nature, although less formal inquiries (for example, open-ended questions during treatment) can also be relevant. This chapter discusses the rationale for periodic and end-point evaluations, the technical issues intrinsic to outcome assessment, and what constitutes a minimally positive treatment outcome. It also cautions, however, that the limitations of psychometric instruments and client/rater defensiveness on assessment instruments may undermine the meaningful psychometric evaluation of outcome in some cases.

Rationale for Evaluating Treatment Effects and Outcome

Modern mental health practice increasingly points to the need to evaluate treatment outcome in work with clients. This increased attention to specific therapeutic effectiveness is an important development and a growing concern for the California Victim Compensation and Government Claims Board. In work with children, such formal evaluation can include parent/caregiver reports of the child's current symptoms and problems, child self-report of current psychological or social functioning, and therapist DSM-IV (American Psychiatric Association, 1994) diagnosis and rating of improvement at termination of therapy. Child and caregiver satisfaction with treatment also can be assessed, although the tendency for most treatment to be rated positively by client consumers, and to be only weakly correlated with treatment outcome measures (Ries, Jaffe, Comtois, & Kitchell, 1999) qualifies the overall meaningfulness of this criterion.

The primary rationale for evaluating treatment outcome is the need for objective data regarding the effectiveness of therapy. Although the clinician may believe that his or her efforts have assisted the client, this conjecture may not be correct. Subjective therapist assessments of treatment outcome can be biased by the clinician's normal need to feel competent and helpful and the understandable need to justify the considerable time and effort involved in some therapy procedures. In turn, the client may overestimate the helpfulness of treatment in response to the demand characteristics of therapy. The client may perceive the therapist's expectations of positive evaluation and respond with feedback that meets that implicit (sometimes unconscious) demand. Finally, children (and others) in therapy may rate therapy outcome positively based on how much they like the therapy or the therapist. Their feelings about the therapist constitute an important issue but do not necessarily correspond to whether trauma-related symptomatology has diminished.

Objective psychological data — usually provided by formal assessment instruments — avoids this potential subjectivity by allowing comparison of a given client's pre-treatment scores to those at the end of treatment. As will be described below, such tests can allow the clinician and others to assess whether therapy has (1) significantly reduced victimization-related symptomatology, and (2) whether the client's current level of functioning approaches that seen in recovered or nonvictimized individuals. This type of data allows the clinician and others to determine, in many cases, whether (1) treatment has been successful and the child no longer needs clinical services, or (2) additional or different treatment is indicated because the child has not improved or recovered sufficiently.

The Need for Baseline Assessment

As indicated in the Assessment chapter, treatment outcome assessment must begin at the initiation of therapy. Administration of psychological tests before or during the first session helps the therapist to develop an accurate clinical picture of the child's psychological symptoms and psychosocial problems. In the optimal situation, these data come from tests that are administered to the child's caregiver(s) and the child. In some instances, structured assessment also involves information from other sources, such as teachers. Finally, the clinician should form a diagnosis (using DSM-IV criteria) at the outset of treatment regarding any psychological disorder the child may have.

A primary advantage of assessment at the beginning of treatment is that it supports the development of specific treatment goals. For example, a child with elevated scores on depression and posttraumatic stress, but not exhibiting sexual problems or "acting out" behaviors, can receive treatment that is targeted to the former but not the latter. Assessment-based treatment is more likely to be focused and efficient because it assists the clinician regarding what are therapeutic targets and what are not.

Unfortunately, a significant minority of abused or traumatized children (and their caregivers) under-report symptoms of trauma or abuse on established psychological measures (Elliott & Briere, 1994), probably for defensive reasons. In addition, some children or caregivers may provide inaccurate data at the onset of treatment (for example, by over-endorsing or randomly responding to symptom items). In the absence of alternatives, such as using a valid parent report in the instance of a non-disclosing child client (or the reverse), assessment-based treatment is not helpful, since such cases lack meaningful clinical data that can be followed over time.

The Need for Assessment at Intervals

In addition to pre- and post-treatment evaluations, periodic assessments are usually indicated for therapy that extends beyond several months. Multiple evaluations allow the clinician and others to determine, on an ongoing basis, what symptoms or problems are responding to treatment and which are not. In addition, some symptoms may spontaneously reappear or exacerbate during extended treatment and thus may require additional attention. Without an ongoing, essentially longitudinal assessment, such improvements and fluctuations are more difficult to ascertain.

Lanktree and Briere (1995) provide an example of the impacts of treatment on different symptoms at different times. In this study, abuse-focused treatment was examined in a reasonably large sample of sexually abused children. Symptom change was measured with the Trauma Symptom Checklist for Children (TSCC; Briere, 1996) and the Children's Depression Inventory (CDI; Kovacs, 1983), administered at three-month intervals. For those in longer-term treatment, the CDI and all TSCC scales but Sexual Concerns decreased significantly after three months of therapy. At six months, those remaining in therapy continued to decrease significantly on the CDI and on the TSCC scales Anxiety, Depression, Posttraumatic Stress, and Sexual Concerns, but not on Anger or Dissociation. At nine months, Anxiety and Posttraumatic Stress continued to decrease (but not the CDI or the other TSCC scales), and at one year those still in treatment showed further improvement on Anxiety, Depression, and Posttraumatic Stress.

Because the authors were interested in studying the naturalistic course of symptom reduction for children in longer-term treatment, no alterations in treatment focus occurred as a function of which symptoms decreased at which point in time. It is likely, however, that if the clinicians in that study had progressively revised their treatment focus at three-months intervals, based on the test data described above, symptoms that took longer to decrease (for example, Sexual Concerns) or decreased less than desired (Anger) might have responded earlier or more substantially.

It should be noted that there were a few instances in the Lanktree and Briere (1995) data where TSCC symptoms temporarily *increased* as a function of treatment — a phenomenon also reported by Friedrich and Reams (1987). This is likely to be due to the temporary activating aspects of re-exposure to painful abuse

memories, or the results of treatment-induced decreases in avoidance defenses. In the latter case, therapeutic improvement may reduce the child's reliance on dissociation, numbing, or denial — a positive outcome that may, nevertheless, make the client appear to worsen on mid-therapy psychological tests. Ideally, these exacerbations are temporary, and signal to the therapist the need to address whatever increased distress emerges during treatment.

The Three-Month Assessment Interval

Based on clinical experience and studies like the one described above, a three-month assessment interval appears reasonable, although this guideline is somewhat arbitrary. It is based on the premise that testing children more often than once every three months may sensitize them to the testing instruments (reducing their effectiveness), whereas testing at intervals longer than three months can deprive the clinician and others of timely clinical information. It should be noted, however, that the final (post-treatment) assessment might not correspond to this interval. For example, a child in therapy for five months would be assessed at intake, again at three months, and finally at termination (two months after the previous testing), whereas a child treated for a year would be assessed at intake, three months, six months, nine months, and at termination.

Primary Areas for Assessment

The impacts of criminal victimization on children can be quite varied. A review of the literature in this area suggests that child abuse and other forms of child maltreatment can be associated with clinically significant attachment disturbance, anxiety and phobias, depression, anger, posttraumatic stress, dissociation, low self-esteem, problems in relationships with peers and authority figures, aggression, excessive or premature sexual behavior, somatic concerns and psychosomatic disorders, sleep disturbance, withdrawal, regression, and scholastic difficulties (Berliner & Elliott, 1996; Kendal-Tackett, Williams, & Finkelhor, 1993; Kolko, 1996). In older children and teenagers, there may be additional problems such as substance abuse, criminality, and early evidence of what may later be diagnosed as personality disorder (Berliner & Elliott, 1996).

Obviously, not all these and related problems can be assessed on an ongoing basis for every client. Instead, the clinician must attend to the child's and caregivers' reports of problem areas, as well as data from other sources such as schools or the criminal justice system. Once a set of problems or symptoms has been determined, available psychological tests or other assessment procedures can be selected that address these specific areas. Generally, the most important areas are anxiety, depression, anger, aggression, posttraumatic stress, self-esteem, relationships with others, and sexualized behavior. The majority of these can be assessed using currently available standardized tests, as described below.

Primary Assessment Instruments

As noted in the Assessment chapter, there are psychological tests available to assess most, but not all, of the most pressing victimization-related problems and symptoms for children. The best known of these are listed below, although other standardized tests are also appropriate.

The Child Behavior Checklist (CBCL, Achenbach, 1991)

The CBCL is one of the most widely used clinical instruments for the assessment of psychological distress in children. It contains 116 items, which are completed by a caregiver or teacher. There is also a self-administered version for children 11 years of age or older, and an observation form on which the clinician can record direct observations of the child. The most common version is the parent version for 4–18 year olds. This instrument has scales that measure both psychopathology (for example, withdrawn, somatic complaints, thought problems, delinquent behavior) and competencies (for example, activities, social, and school). Because the CBCL measures not only symptomatology but also social functioning, it can be an effective pre-post measure for treatment outcome.

Trauma Symptom Checklist for Children (TSCC, Briere, 1996)

The TSCC is a 54-item, standardized, self-report instrument that evaluates trauma-related symptomatology in children ages eight to sixteen, including the effects of child abuse and neglect, other interpersonal violence, and witnessing trauma to others. The TSCC has two validity scales: *Underresponse* (UND) measures abnormally low endorsement of commonly endorsed symptoms; and *Hyperresponse* (HYP) measures excessive endorsement of rarely endorsed symptoms. It has six clinical scales: *Anxiety*, *Depression*, *Posttraumatic Stress*, *Sexual Concerns*, *Dissociation*, and *Anger*. Two of these scales have subscales: *Sexual Concerns* contains *Sexual Preoccupation* and *Sexual Distress*; *Dissociation* contains *Fantasy* and *Overt Dissociation*).

The Trauma Symptom Checklist for Young Children (TSCYC, Briere, 1997)

The Trauma Symptom Checklist for Young Children (TSCYC) is a 90-item caregiver-report measure of children's trauma- and abuse-related symptomatology. It contains two reporter validity scales (*Atypical Response* and *Response Level*) and nine clinical scales (*Posttraumatic Stress — Intrusion*, *Posttraumatic Stress — Avoidance*, *Posttraumatic Stress — Arousal*, *Posttraumatic Stress — Total*, *Sexual Concerns*, *Anxiety*, *Depression*, *Dissociation*, and *Anger/Aggression*). At the time of this writing, the TSCYC normative studies had not yet been completed, although validity research indicates good psychometric quality. Until normative data are available, this measure should be seen as a structured symptom review rather than as a measure of relative symptom severity.

The Child Sexual Behavior Inventory (CSBI, Friedrich, 1998)

The CSBI is a standardized 38-item instrument upon which a female caregiver describes sexual behaviors that she has observed in a child during the prior six months. The CSBI is intended for use with children between the ages of 2 and 12 who have been or are suspected of being sexually abused. The instrument evaluates nine domains: boundary problems, exhibitionism, gender role behavior, self-stimulation, sexual anxiety, sexual interest, sexual intrusiveness, sexual knowledge and voyeuristic behavior. The CSBI yields a total score and two scale scores: *Developmentally Related Sexual Behavior*, which reflects the level of age and gender-appropriate sexual behavior; and *Sexual Abuse Specific Items*, which consists of items that have been empirically related to a history of sexual abuse. The CSBI is currently the best measure of sexual behavior in children, and probably should be used in any instance where sexual reactivity or sexual distress is a treatment issue.

The Children's Depression Inventory (CDI, Kovacs, 1992)

The CDI is a 27-item measure of depression in children and adolescents aged 7 to 17. The CDI assesses depressed mood, anhedonia, vegetative symptoms, negative self-evaluation, and depressive behavior. The CDI is the most common standardized measure of depression in children and adolescents and has been shown to have good reliability and validity (Kovacs, 1992). Exposure to childhood trauma, especially sexual abuse, is correlated with CDI scores (Mennen, 1994). Treatment for sexual abuse appears to decrease children's CDI scores (Lanktree & Briere, 1995).

Recommended Test Battery

The specific outcome instruments chosen for a given child client will vary according to the specific issues to be addressed in therapy. However, optimal outcome assessment approaches usually include:

- At least one general test that reviews a range of common symptoms and behaviors, ideally including social functioning (for example, the CBCL)
- At least one test that is specific to trauma (for example, the TSCC)
- If necessary, one test relevant to specific problems or symptoms the child may experience (for example, the CSBI for children with possible sexual reactivity or the CDI for a child with significant depressive symptoms)

Whenever possible, test data should be obtained from both the child and a knowledgeable caregiver, because each source provides a different perspective and one might be more forthcoming or accurate than the other.

Definition of Successful Treatment at Post-Treatment Assessment Point

Implicit in the notion of outcome evaluation is some criterion of treatment success. This criterion is necessarily broad, since different problems and measurement systems have different thresholds for what is considered positive outcome. However, positive treatment outcome can be defined as at least one of the following:

- Resolution of a psychological disorder (for example, depressive, anxious, posttraumatic, conduct), assessed by clinical or structured diagnostic interview, in the sense that the DSM-IV criteria for that disorder are no longer met.
- The client's scores on a standardized psychological test or scale are no longer in the clinical range for that test.
- The client's score on a given test or scale is significantly lower at post-test, often considered to be at least one standard deviation lower (using the test's normative data) than at pre-test.

Success also can be defined in terms of other more social or behavioral outcomes, such as returning to school, successful integration into a peer network, or parent/caregiver anecdotal reports of symptom resolution. However, some of these issues are not well measured by current psychological tests and thus may not be easily quantifiable.

Conclusion

The Task Force makes several suggestions regarding therapy outcome measurement before, during, and after treatment of child victims. These are:

- Whenever possible, treatment outcome should be measured formally, using structured, standardized measures, in order to avoid potential biases associated with both therapist and client subjective assessment.
- Baseline and posttreatment assessments should be conducted to examine whether treatment was successful or whether more or different treatment should be attempted.
- In longer-term therapy, repeat assessments should be done at three-month intervals. Data from these assessments can inform treatment by pointing out areas requiring greater attention, as well as possible adjustments the therapist might make in whatever treatment is provided.
- Not all potential victimization impacts can be assessed for treatment outcome, but there are several tests that, when used together, cover the majority of important areas.
- Successful treatment outcome may be signaled by significant reductions in pre- versus post-treatment scores, by posttreatment loss of a previous diagnosis, or by the client's posttreatment scores no longer falling in the clinical range for a given instrument.
- Psychometrically based evaluation of success rests, minimally, on the sensitivity of the instrument and the willingness of the child (or other rater) to report symptoms accurately. In the absence of either of these two conditions, treatment outcome must be assessed in some other manner.

Assessment-based therapy, when successfully implemented, is likely to provide more focused and efficient treatment of child trauma victims than assessment-blind treatment. As such, the appropriate use of periodic psychometric evaluation of client functioning and treatment progress is recommended.

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